MedStar Accountable Care
MDCTO-0090
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information				
Application ID Number	MDCTO-0090			
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.			
Organization Site Name	MedStar Accountable Care, LLC			
DBA Name	MedStar Accountable Care			
Website (if applicable)	http://www.medstarmedicarechoice.com/accountable-care			
Ownership & Legal Structure				
Owned by Health Care Organization	Yes			
Name of Parent Organization	MedStar Health			
Legal Structure	Maryland Limited Liability Company			
Service Area				
Counties Served	Anne Arundel County; Baltimore County; Baltimore City; Calvert County; Charles County; Harford County; Howard County; Montgomery County; Prince George's County; Saint Mary's County			
Partnerships				
Formal Partnerships	Partnerships include, but are not limited to, Baltimore Population Health Workforce Collaborative; Baltimore City Accountable Health Communities; Community Health Partnership of Baltimore; Nexus Montgomery; Regional Partnership for Health System Transformation - Totally Linking Care.			
Informal Partnerships	N/A			
Services Offered				
Tele-diagnosis	Not a current or planned activity or service			
Tele-behavioral health	Planned for future			
Tele-consultation	Currently in place			
Remote Monitoring	Currently in place			
Other	Currently in place			
HIT				
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.			
HIT Vendor	Evolent Health	Cerner	Cerner	NavHealth
HIT Product Name	Identifi	HealtheRegistries	MedConnect	CareJourney

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	5	N/A
Behavioral Health Counselor	N/A	N/A
Billing/Accounting Support	2	N/A
Care Managers - RNs	17	7
Care Managers - Medical Assistants	N/A	N/A
Care Managers - RN Supervisors and Clinical Operations Lead	3	N/A
Community Health Workers	5	N/A
Data Analysts	2	N/A
Health IT Support	2	N/A
Licensed Social Workers	2	N/A
Nutritionist	1	7
Pharmacists	1	2
Practice Transformation Consultants	N/A	N/A
Psychiatrist	N/A	1
Psychologist	N/A	N/A
Transitional Care Coordinator	1	N/A
Pharmacy Technician	4	7

Vision

The MedStar Health (MSH) CTO (legally MedStar Accountable Care) will support practices' care delivery transformation by partnering with practices to understand where they are in the care transformation journey, how the CTO can best support their transformation, and providing appropriate resources to create a comprehensive primary care ecosystem that meets the requirements of the MDPCP. The MSH CTO will leverage MedStar's experience managing care for approximately 150,000 covered lives across MedStar's value-based arrangements, including a MSSP Track 3 ACO, a Managed Care Organization participating in the Maryland HealthChoice program, and commercial agreements. The MSH CTO will particularly leverage ACO and health plan expertise engaging MFFS beneficiaries, partnering with providers to make processes more seamless, providing holistic longitudinal and episodic patient-centered care management, and leveraging social services to extend care into the community. To support practices' care delivery transformation, the MSH CTO is poised to assist practices with the primary drivers of Advanced Primary Care: access and continuity of care, care management, comprehensiveness and coordination of care, care for planned health outcomes, and beneficiary and caregiver experience. Specifically, a practice-based Lead Care Manager will support systematic identification and resolution of gaps in care, care coordination throughout the medical neighborhood, and collaboration with members of the extended interdisciplinary care team. To identify patients appropriate for care management programs, the MSH CTO will use predictive modeling that synthesizes clinical data, utilization history, and demographics to identify and risk-stratify beneficiaries by impactability; leverage CRISP ENS feeds; and rely on provider referrals. Care managers will follow clinical guidelines to provide both longitudinal care management for high risk/complex patients as well as 30-day transitional care management for beneficiaries discharging from acute and selected post acute facilities. For patients identified for care management programs, care managers will conduct a comprehensive assessment including health status, condition-specific concerns and activities of daily living, clinical history, social need and community resource identification; develop a care plan with patient-centered goals; and work with patients, their primary care provider, and other clinicians (such as behavioral health, pharmacy and nutrition professionals) throughout their engagement to meet the jointly defined goals. For beneficiaries with complex psychosocial or behavioral health needs, a Clinical Social Worker will address the beneficiary's identified needs and partner closely with a Registered Nurse to meet the beneficiary's behavioral, medical, and social needs. Arriving at beneficiary-centered goals may include education (including disease, risk factors, symptoms, and medications), lifestyle management, medication review, identification and resolution of barriers to health, and wellness screenings. Using claims and other data made available by CMS, the MSH CTO can assist practices with analyzing where beneficiaries predominantly receive acute, post acute, and specialist care and partner to identify and deploy strategies to improve coordination with identified providers. Predictive modeling will identify beneficiaries at risk for hospitalization, allowing the interdisciplinary care team to engage beneficiaries before they require hospitalization or emergent care. The CTO will be prepared to further support planned care for health outcomes by supporting care gap closure through point of care solutions-including disease registries and EMR tools-coupled with workflow modifications. To engage beneficiaries and caregivers in the design of their healthcare experience, the MSH CTO can help orchestrate local PFACs using MedStar Health's experience leading hospital and system PFACs.

Approach to Care Delivery Transformation

The MedStar Health (MSH) CTO will support practices' transformation towards high quality team-based care by enabling delivery of more holistic beneficiary-centered care than is currently feasible with the resource constraints faced in primary care. The MSH CTO will support partner practices with care coordination services, care transition support, beneficiary screening, data tools and informatics, and practice transformation assistance. In collaboration with primary care practitioners, the Lead Care Manager (employed by practice or CTO) will coordinate care throughout the medical neighborhood –including beneficiary-centered, goal-directed care management provided by an interdisciplinary care team– for beneficiaries identified as complex or high risk through predictive modeling or clinical judgment. For beneficiaries transitioning home after acute care, care managers will support beneficiaries by clarifying discharge instructions, facilitating follow up appointments, and coordinating with home supports. The CTO will also partner with practices to facilitate timeliness of notifications and co-management across providers. Care coordination and transition services will include patient self-management support through education, lifestyle management, medication review, and health barriers elimination, as appropriate. Screening for social needs and navigation to social service organizations is a standard part of the assessment process for beneficiaries receiving care management that can be scaled readily. Track 2 practices can expect to learn from MedStar's experience screening using the AHC Health Related Social Needs screening tool. The CTO is also prepared to impart MedStar Health's lessons learned communicating across disparate EMRs, utilizing CRISP, and optimizing the EMR to facilitate timely, proactive patient care. The CTO can catalyze practice transformation by educating practices on performance improvement concepts and building internal improvement capabilities.